THE GEORGE WASHINGTON UNIVERSITY
DEPARTMENT OF ATHLETICS AND RECREATION
CAMP/CLINIC HEALTH FORM

Camp/Clinic Name _____ Dates of Participation _____

Name _____ DOB _____ Gender _____ Age _____
Last First Initial

Home Address _____
Number & Street City State Zip Code

Parent/Guardian _____ Relationship _____

Phone (H)_____ (W)_____ (C)_____

Parent/Guardian _____ Relationship _____

Phone (H)_____ (W)_____ (C)_____

Emergency Contact Names

1. Name_____ Relationship _____

   Phone (H)_____ (W)_____ (C)_____

2. Name_____ Relationship _____

   Phone (H)_____ (W)_____ (C)_____

Health History

Date of Last Tetanus Shot _____

Name of Child's Physician _____ Phone _____

Insurance Company _____ Policy/Group Number _____

*Allergies: _____Poison Ivy _____ Insect Stings _____Foods _____ Penicillin _____Other *If yes, please list _____

_____

(If your child requires medication during program hours please contact the Camp Director immediately to discuss.)

List any concerns which may affect your child's full participation in daily activities and or restrictions while in camp (e.g., swimming, special diet, strenuous activity, other) _____

_____

_____

Important: Please notify the camp director if this camper is exposed to any communicable diseases during the three weeks prior to camp attendance.

This health form is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me as listed above. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected or the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.

Signature:_____ Date: _____